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Patient Registration Sheet

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Child's Name:	Date of Birth:	Mother's Maiden Name:		
Address:	City:	St:	Zip:	Sex:
For Patient Portal - Primary Parent Email Address:			Language:	

RACE: **(Please check the appropriate box)**

☐ AMERICAN INDIAN / ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN
☐ OTHER PACIFIC ISLANDER ☐ WHITE ☐ MORE THAN ONE RACE ☐ REFUSED TO REPORT

ETHNICITY: (**Please check the appropriate box)**

☐ HISPANIC / LATIN AMERICAN ☐ NON-HISPANIC / LATIN AMERICAN ☐ REFUSED TO REPORT

Parent/Responsible Party:		Sex:	Date of Birth:
Address:	City:	St:	Zip:
Soc. Sec.#:	Home Ph.:	Cell:	Work:
Employer:		Occupation:	
Employer Address:	City:	St:	Zip:
Other Parent Name:		Sex:	Date of Birth:
Address:	City:	St:	Zip:
Soc. Sec.#:	Home Ph.:	Cell:	Work:
Employer:		Occupation:	
Employer Address:	City:	St:	Zip:
Emergency Contact Name: (Outside the household) **:**			
Home Ph.:	Cell Ph.:	Relationship:	

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Carrier Name:	Carrier Name:
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:
Policy ID:	Policy ID:
Group #:	Group #:
Co-Pay:	Co-Pay:
Relation to Patient:	Relation to Patient:

This form was completed correctly to the best of my knowledge. Please inform the office of any changes.

Signature of Parent or Responsible Party **Relationship to the Patient** **Date**